STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K033	A. BUILDING _____ B. WING _____	R-C 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOINTED TOUCH HOME HEALTH LLC	2021 E 52ND ST STE 100 A-E INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	{G 000}		

This was a revisit for an extended federal home health agency complaint survey conducted on 4-9, 4-10, 4-13, 4-14, 4-14 and 4-16-15.

Complaint #: IN00153329; Substantiated - Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.

Survey date: 5-21-2015

Complaint #: IN 00153329

Facility #: 011457

Medicaid Vendor: 200891860

Current Census: 17 Skilled patients
24 Home Health Aide only patients
41 Total

Five (5) condition level deficiencies and twenty (20) standard level deficiencies were found corrected during this survey.

Anointed Touch Home Health, LLC, was found to be in compliance with 42 CFR 484 for home health agencies.

Anointed Touch Home Health, LLC, is precluded from providing a home health aide training and competency evaluation program for a period of 2 years beginning 4-16-2015 to 4-16-17 for having been found out of compliance with the Conditions of Participation 42 CFR 484.10 Patients Rights; 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 484.36 Home

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	Continued From page 1 Health Aide Services, and 42 CFR 484.52 Evaluation of the Agency's Program. QR: JE 5/26/15	{G 000}		
{G 173}	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by:	{G 173}		